STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395742	A. BLDG: 00 B. WING:	04/21/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SOUTHWESTERN NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **452302**	**500 NORTH LEWIS RUN ROAD PITTSBURGH, PA 15122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on an abbreviated survey in response to four complaints completed on 4/21/23, it was determined that Southwestern Nursing and Rehabilitation was not in compliance with the following requirements of 42 CFR Part 483, Subpart B Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0656 SS=D		F 0656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0656 SS=D	Continued from page 1 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. The plan of correction represents the facility's credible allegation of compliance. R#1 was reassessed for elopement risk on April 3, 2023, and care plan was updated to identify interventions to prevent elopements. Current residents' elopement assessments were reviewed on April 3, 2023 and reassessments completed on April 19, 2023. Care plans for residents at risk were reviewed and updated as necessary with interventions to prevent elopement. Staff were educated on potential risk factors of elopement and implementing interventions per	Completion Date: **05/11/2023** Status: **APPROVED** Date: **05/09/2023**

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F 0656 SS=D	Continued from page 2 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656	resident's care plan. Education with all in-house staff was completed by the director of nursing or designee by 5.8.2023 and new hires and contracted staff prior to working their next shift. Audit will be completed of new residents for elopement risk factors and care plan initiated as necessary daily for 5 days, weekly for 3 weeks then monthly for 2 months. Results and audits will be presented at the Quality Assurance Performance Improvement Committee meeting for review and recommendations.	

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F 0656 SS=D	Continued from page 3 Based on review of facility policies, clinical record review and staff interview, it was determined that the facility failed to develop a person-centered care plan related to elopement and wandering/exit-seeking behavior which resulted in a resident who subsequently eloped from the facility for one of six residents (Resident R1). Findings include: The facility "Care plans: comprehensive person-centered" policy last reviewed on 10/31/22, indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the residents' physical, psychosocial and functional needs is developed and implemented for each resident. Care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The care plan will reflect treatment goals, reflect currently recognized standards of practice, aid in preventing or reducing declining in function, and incorporate identified	F 0656		

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F 0656 SS=D	Continued from page 4 problem areas. The facility policy "Elopement of Patient" reviewed 10/31/22, indicated patients/residents will be provided a safe environment regardless of orientation status and to supervise those residents at risk for elopement based on the comprehensive care plan of each resident. Review of the clinical face sheet indicated that Resident R1 was admitted on 2/23/23. Review of the Admission MDS dated 2/23/23, included diagnoses of Cerebral Atherosclerosis (condition of the arteries in the brain becoming hard and narrow) and Vascular Dementia (type of brain degenration that contributes to problems with reasoning, planning, judgement, memory and other thought processes). Review of the admission assessment completed on 2/23/23, indicated that Resident R1 was not documented as having behavioral symptoms such as physical aggression, rejection of care, anxiety about	F 0656		

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F 0656 SS=D	Continued from page 5 surroundings, restlessness, history of exit seeking, history of wandering, and verbalization of desire to exit. Review of a medical practitioner progress note dated 3/24/23, at 11:03 a.m. indicated that Resident R1 was alert and confused at his baseline. Review of Resident R1's plan of care initiated 2/23/23, failed to include a care plan with goals and interventions related to elopement/wandering Review of Resident R1's Admission MDS dated 3/1/23, Section C: Cognitive Patterns, revealed the Resident R1 had a BIMS score of 6. Brief Interview for Mental Status is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of facility submitted documents, dated	F 0656		

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F 0656 SS=D	Continued from page 6 4/3/23, incident report investigation indicated Resident R1 eloped from the facility 4/3/23, at approximately 10:07 a.m. Continued review indicated that Resident R1 exited out the second-floor locked door, went down the hallway towards the kitchen. Resident was later found on 4/3/23, at 10:42 a.m. (approximately 35 minutes later). During an interview on 4/19/23, at 10:00 a.m. Registered Nurse (RN) Employee E2 stated the day Resident R1 eloped, he was wandering and found by the doors down the hallway; information was not added to the care plan for potential for elopement risk. During an interview on 4/20/23, at 12:00 p.m. with Resident Family RF1 indicated that she was notified on 4/3/23, by phone stating Resident R1 was missing; Resident Family RF1 was worried about Resident R1 getting into a stairwell. Resident Family RF1 also stated that this was one of the reasons why the hospice respite stay was given, due to the	F 0656		

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F 0656 SS=D	Continued from page 7 increased confusion During an interview conducted on 4/19/23, at 2:30 p.m., Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed the events of the facility submitted documents and confirmed Resident R1 had a diagnosis of cerebral atherosclerosis and vascular dementia, but that no wander risk was identified on admission. Elopement assessment was completed but did not identify the Resident R1 at risk for elopement. Due to this finding the Resident R1 care plan was not implemented to reflect the diagnosis of vascular dementia. The facility failed to develop a person-centered care plan related to dementia and wandering/exit-seeking behavior related to Resident R1. This failure resulted in Resident R1 subsequently eloping from the facility. 28 Pa. Code 211.10(c) Resident care polies.	F 0656		

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F 0656 SS=D	Continued from page 8 28 Pa. Code: 211.11(a)(b)(c)(d) Resident care plan. 28 Pa. Code: 211.12 (c)(d)(1) Nursing services.	F 0656		
F 0689 SS=J		F 0689		

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F 0689 SS=J	Continued from page 9 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	On 4/3/2023 R1 was assessed for injury and had no negative outcomes. Resident was seen by the nurse practitioner at time of incident on 4.3.23 with no new orders. Medical Director notified of incident. Responsible party, resident's wife, notified of incident. The resident's wife was offered alternate placement for resident, and she declined. Resident's elopement assessment was updated, and care plan updated accordingly. Resident was added to the elopement binder. Resident was placed on a 1:1 ·until behaviors resolved. The exit door was adjusted to close faster upon being opened. Facility conducts daily door checks to ensure proper closure. R1 was assessed for elopement risk on admission February 23, 2023, as not being at risk. Re-evaluation elopement risk completed on April 3, 2023, as being a 5 which constitutes being at risk. Interventions were implemented. Resident reassessed again on April 19 and scored a 5.	Completion Date: **05/11/2023** Status: **APPROVED** Date: **05/09/2023**

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F 0689 SS=J	Continued from page 10	F 0689	The care plan for elopement risk was reviewed and updated. Current residents' elopement assessment were completed on April 19, 2023. No new residents were identified at risk for elopement. Care plans were reviewed for the current residents at risk and updated as necessary. Missing persons binder was reviewed to validate current information for residents at risk. Facility will ensure adequate supervision/monitoring of residents identified -at risk for elopement by educating staff on potential risk factors and implementing interventions per resident's care plan. Education will be completed with all in-house staff by 4.20.23 and all new hires and contracted staff prior to working their next shift. Facility reviewed elopement policy with current staff. Education was completed with current in-house staff on 4.20.23 and all new hires and contracted staff prior to working their next shift. Staff will be trained on recognizing	

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F 0689 SS=J	Continued from page 11	F 0689	signs and symptoms of resident elopement before the start of their shift. Education was completed with in-house staff by 4.20.23 and all new hires and contracted staff prior to working their next shift. - Signs and Symptoms to be aware of and notify nurse/supervisor. That resident may be at risk of attempting to leave the facility. IF you notice any of these 5/5 notify your charge nurse/supervisor 1. Residents that verbalize they want to go home. 2. Residents that are walking aimlessly about the unit with coat and bag and this is not normal behavior. 3. Residents that are walking or moving wheelchair towards exit doors and attempting to open them. 4. Residents that request assistance to leave the facility to either a staff member or a visitor. 5. Residents that are new admissions are having difficulty adjusting to life in the facility. 6. Aimless wandering about the unit that is outside the norm.	

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F 0689 SS=J	Continued from page 12	F 0689	7. Residents attempting to open windows/doors or enter elevator/stairwell. Directed in-service training will be completed by LW consulting on May 3, 2023 on F689 Free of Accidents, Hazards/Supervision. The current staff will be educated on that day or prior to next scheduled shift. Audits on monitoring residents with newly displayed risk factors of elopement and any new interventions implemented based on the displayed risk factors were care planned was completed daily for 5 days, weekly for 3 weeks and monthly for 2 months. Results and audits will be presented at the Quality Assurance Performance Improvement Committee meeting for review and recommendations.	

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F 0689 SS=J	Continued from page 13 Based on facility policy review, clinical and facility record review, facility provided documents, and staff interviews, it was determined that the facility failed to provide adequate supervision for a resident resulting in elopement (resident leaves the premises or a safe area without the facility's knowledge). This failure created an immediate jeopardy situation for one of 93 residents (Resident R1). Findings include: A review of the State Operations Manual (SOM) defines elopement as "a situation in which a resident leaves the premises or a safe area without the facility's knowledge". A review of the facility policy "Elopement/ Missing Resident" reviewed 10/31/22, states that the facility will provide a safe environment for all residents regardless of orientation status and to supervise those residents at risk for elopement based on the comprehensive assessment and specific care plan for each resident. Policy also states the person	F 0689		

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F 0689 SS=J	Continued from page 14 identifying that a resident is missing or unaccounted for immediately notifies the charge nurse or the RN supervisor. A review of the Resident Assessment Instrument 3.0 User's Manual (tool used for the completing the Minimum Data Set (MDS- periodic assessment of care needs) effective October 2019, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment A review of the MDS dated 2/28/23, indicated that the diagnoses remained current and that Resident R1 had a BIMS score of 6, which indicated severe impairment. Section GG of this MDS, which defines functional abilities, indicated resident was able to utilize a walker with assistance. Resident is mobile in a wheelchair.	F 0689		

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F 0689 SS=J	Continued from page 15 A review of the Admission Record indicated Resident R1 was admitted to the facility on 2/23/23, with diagnoses that included cerebral atherosclerosis (a condition of the arteries in the brain becoming hard, thick, and narrow decreasing the blood flow to the brain) and Vascular Dementia (brain damage caused by multiple strokes). Resident admission was scheduled as a hospice respite stay due to increased behaviors, wandering at home, and Resident R1's family having difficulty taking care of Resident R1. Resident R1 then was admitted to long term care on 3/7/23. A review of the Elopement Assessment Form dated 2/23/23, indicated that Resident R1 had zero of nine total factors/contributors indicating elopement risk. Elopement form instructions indicated that just one factor identified the resident at risk for elopement. Factors that are reviewed are: 1. Does the resident have a history of or an attemped elopement while at home?	F 0689		

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	395742	A. BLDG: __00_____ B. WING: _____	04/21/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SOUTHWESTERN NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 452302	500 NORTH LEWIS RUN ROAD PITTSBURGH, PA 15122

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F 0689 SS=J	Continued from page 16 2. Does the resident have a history of or attempted leaving the facility without informing staff? 3. Has the resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit or door? 4. Does the resident wander? 5. Is the wandering behavior a pattern, goal directed (i.e. specific destination mind, going home ect)? 6. Does the resident wander aimlessly or non-goal directed (i.e. confused, moves without purpose, may enter others' rooms and explore others' belongings)? 7. Is the residents wandering behavior likely to affect the safety or well being of self/others? 8. Is the residents wandering behavior likely to affect the privacy of others? 9. Has the resident been recently admitted or re-admitted (within the past 30 days) and is not accepting the situation? A review of the resident admission documents and history indicated that the resident did have at least one factor that triggered the resident as an elopement risk, despite the facility indicating there	F 0689		

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F 0689 SS=J	Continued from page 17 were 0. This was indicated upon admission for the initial stay for respite care prior to the decision to stay long term. A Nurse Practitioner note dated 3/4/23, indicated Resident R1 was "very confused at baseline." A review of the clinical record on 4/19/23 at 10:00 a.m. indicated that the nurse practitioner saw Resident R1 on a monthly review dated 3/24/23 and revealed Resident R1's status as very confused at his baseline. A review of Resident R1's care plan dated 2/28/23, failed to show documented risks, goals or interventions related to elopement or wandering. A review of Resident R1's physician order dated 2/23/23 through the elopement date of 4/3/23, failed to show any documented orders or protocols to follow for Resident R1 in case of elopement or wandering behaviors.	F 0689		

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F 0689 SS=J	Continued from page 18 A review of Resident R1's progress notes dated 4/1/23 indicated: "Resident does not follow commands". A review of facility provided documents, dated 4/3/23, indicated that on 4/3/23, at 10:07 a.m. the facility had a resident elopement. A review of a statement from Registered Nurse Employee E2 dated 4/3/23, indicated that Therapy Employee E1 was looking for Resident R1 for therapy. RN Employee E2 looked around the second floor nursing station then down the halls and then into the second floor rooms. Resident R1 was not able to be located. Then Registered Nurse Employee E2 went to the third floor to see if the Resident R1 was at activities. Once Resident R1 was not able to be located, RN Employee E2 notified the Assistant Director of Nursing (ADON) as directed in the policy. A review of the facility Elopement Sheet documentation dated 4/3/23, indicated that the	F 0689		

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F 0689 SS=J	Continued from page 19 elopement code was called at 10:07 a.m. This documentation also indicated that the Nursing Home Administrator (NHA) and Director of Nursing (DON) were notified at 10:15 a.m. A call was placed to 911 at 10:32 a.m. when Resident R1 was still unable to be located. Documentation stated that Resident R1 was found at 10:42 a.m. in the hallway between the locked second floor doors and the kitchen. Directly outside these coded doors is a long hallway that is not part of the physical layout of the nursing home. A left out of these doors would lead to a set of double doors that would exit to a back parking lot; a right would lead down a long hallway, past a set of staff lockers, an exit to an enclosed courtyard that is staff access only, and then the kitchen. A person in this area may not come into contact with any staff until the next meal or if the nursing center would call the kitchen for a food request. During an interview on 4/19/23, at 2:00 p.m. RN Employee E2 indicated on 4/3/23, Resident R1was last seen at the end of the short hall and was brought	F 0689		

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F 0689 SS=J	Continued from page 20 back to the second floor nursing station and on 4/3/23, RN Employee E2 also indicated that it was witnessed that NA Employee E3 was talking with Resident R1 at 9:40 a.m. by the nurses station. During an interview on 4/19/23, at 2:45 p.m., the NHA indicated the facility does not have a wander guard system in place just locking doors that are coded and the doors do not have alarms. During an interview on 4/19/23, at 3:50 p.m., the Maintenance Director Employee E4 stated that the second floor doors that lead to the hallway that Resident R1 exited was slow closing. Maintenance Director Employee E4 also stated that after the elopement the doors were adjusted to close faster. A review of the maintenance log from 4/1/23 through 4/3/23 shows the facility did daily checks and indicated the maintenance department just checks that the doors lock; not how long the doors take to close.	F 0689		

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F 0689 SS=J	Continued from page 21 A review of a written statement from Nurse Aide (NA) Employee E5 dated 4/3/23, indicated they did not see Resident R1. A review of a written statement from Nurse Aide (NA) Employee E6 dated 4/3/23, indicated they did see Resident R1 by the nurses station at 8:30 a.m. A review of a written statement from Nurse Aide (NA) Employee E7 dated 4/3/23, indicated they did not see Resident R1 at all. A review of a written statement from NA Employee E8 dated 4/3/23, indicated they observed Resident R1 at 7:30 a.m., before starting to give care in a different room. During an interview on 4/20/23, at 12:00 p.m. with Resident Family RF1 indicated that she was notified on 4/3/23, by phone stating Resident R1 was missing; Resident Family RF1 was worried about Resident R1 getting into a stairwell. Resident Family RF1 also stated that this was one of the reasons	F 0689		

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F 0689 SS=J	Continued from page 22 why the hospice respite stay was given, due to the increased confusion. During an interview on 4/20/23, at 1:20 p.m., the NHA stated the facility did an investigation into the elopement and found the incident happened due to one of the kitchen/dietary staff going through the door and not making sure the door closed and the door not closing fast enough to limit the risk of residents eloping out of the doors. During an interview on 4/19/23, at 11:20 a.m. the NHA confirmed the facility failed to provide adequate supervision for Resident R1 resulting in elopement. This failure created an immediate jeopardy situation. During an interview on 4/19/23, at 4:18 p.m. the NHA and the DON were made aware that Immediate Jeopardy (IJ) existed for one of six residents (Resident R1) residing in the facility. The IJ template was provided to facility administration at that time and a corrective action plan was	F 0689		

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F 0689 SS=J	Continued from page 23 requested. Notification on 4/19/23, at 7:52 p.m. an acceptable Corrective Action Plan was received which included the following interventions: Immediate Action: Resident R1 was assessed after the elopment to determine any injury, none at that time. Resident R1 elopement assessment was updated and care plan was updated accordingly. Resident Family RF1 was offered alternate placement but refused for Resident R1. Residents: Facility will re evaluate all residents to ensure elopement behaviors are identified; update the care plan as needed. Audit will be completed by 4/19/23. Facility will ensure adequate supervision/monitoring of residents identified at risk for elopement by educating staff on potential risk factors and implementing interventions per residents care plan. Education will be completed with all in	F 0689		

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F 0689 SS=J	Continued from page 24 house staff by 4/20/23, and all new hires and contracted staff prior working their next shift. Facility will review and/or revise elopement policy with all staff. Whole house audit was conducted by the NHA and DON on elopement risk with updated assessments done on every resident. No further residents identified to be at risk. System correction: Whole house education for all departments including nursing, maintenance, therapy, housekeeping, laundry, dietary, administrative, social services, and activities, also to include agency and hospice staff was conducted and completed regarding elopement policy, identifying signs and symptoms of residents potential for elopement, and potential risk factors and interventions for residents care plan. The maintenance department updated daily work sheet on door functioning. Education was conducted by DON or designee via telephone or in person meetings. In person education was completed on	F 0689		

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F 0689 SS=J	Continued from page 25 4/19/23 through 4/20/23, with any remaining staff getting a voice message to see the DON or designee before starting shift. Elopement policy and elopement binder was updated on 4/19/23. Monitoring: Audits and timed closing of the doors were initiated by Maintenance staff and documented daily. Audits and monitoring, supervision, and interventions will be completed daily for five days, weekly for three weeks, and monthly for two months. Results and audits will be presented at the Quality Assurance Improvement Committee meeting for review and recommendations. A review of Resident R1's care plan on 4/20/23, indicated the plan of care was updated on 4/3/23, after the incident. Continued review of ten sampled charts verified the part of the plan that residents were re-evaluated for identifying elopement behaviors. During an interview with RN Employee E2 on	F 0689		

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F 0689 SS=J	Continued from page 26 4/20/23 at 10:00 a.m. it was confirmed that she had received the education for elopement policy, potential risk factors, interventions for resident care plans, and education on identifying signs and symptoms of resident potential for elopement. During an interview with RN Employee E4 on 4/20/23 at 10:05 a.m. confirmed that she had received the education for elopement policy, potential risk factors, interventions for resident care plans, and education on identifying signs and symptoms of resident potential for elopement. During an interview with RN Employee E5 on 4/20/23 at 10:10 a.m. confirmed that she had received the education for elopement policy, potential risk factors, interventions for resident care plans, and education on identifying signs and symptoms of resident potential for elopement. During an interview with RN Employee E6 on 4/20/23 at 10:15 a.m. confirmed that she had received the education for elopement policy,	F 0689		

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F 0689 SS=J	Continued from page 27 potential risk factors, interventions for resident care plans, and education on identifying signs and symptoms of resident potential for elopement. During a phone interview with License Practical Nurse (LPN) Employee E7, that works overnight 7:00 p.m. to 7:00 a.m. shift, on 4/20/23 at 1:00 p.m. confirmed that she had received the education for elopement policy, potential risk factors, interventions for resident care plans, and education on identifying signs and symptoms of resident potential for elopement. During a phone interview with NA Employee E8, that works on the 3:00 p.m. to 11:00 p.m. shift, on 4/20/23 at 1:10 p.m. confirmed that she had received the education for elopement policy, potential risk factors, interventions for resident care plans, and education on identifying signs and symptoms of resident potential for elopement. During interviews on 4/20/23, from 9:00 a.m. through 2:00 p.m. 42 total staff employees	F 0689		

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F 0689 SS=J	Continued from page 28 confirmed they had received education on elopement policy, identifying signs and symptoms of residents potential for elopement, and potential risk factors and interventions for residents care plan. Total of nine staff members was called for phone interviews and all staff interviewed by phone confirmed they had received the education via phone call. Facility provided documentation and sign in sheets verifying 80 staff members have received the education in person and 41 staff members received a phone call about the education . The IJ was lifted on 4/20/23, at 2:38 p.m. when the action plan implementation was verified. During an interview on 4/20/23, at 3:00 p.m. the NHA confirmed the facility failed to provide adequate supervision for one resident resulting in elopement. This failure created an immediate jeopardy situation for one of 93 residents (Resident R1).	F 0689		

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F 0689 SS=J	Continued from page 29 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(e)(1) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.	F 0689		

Certified End Page

SOUTHWESTERN NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 452302

SURVEY EXIT DATE: 04/21/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

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